DEPARTMENT OF HEALTH & HUMAN SERVICES
Survey and Certification Group
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CMS/
CENTERS for MEDICARE & MEDICAID SERVICES

Survey and Certification Group

January 15, 2008

Linda Krulish, PT, MHS, COS-C
President
OASIS Certificate and Competency Board, Inc
223 East Main Street
New Iberia, LA. 70560

Dear Ms. Krulish:

Thank you for your letter of January 7, 2008 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The attached questions and answers have been reviewed by CMS staff and consensus on the responses has been achieved. As deemed valuable for providers, OASIS Education Coordinators and others, we will consider incorporating these questions and answers into future updates to the CMS Q&As posted at https://www.qtso.com/hhadownload.html, and/or in future revisions to the OASIS User Manual, Chapter 8, Item-by-item Tips.

In the meantime, you are free to distribute these responses through educational offerings sponsored by the OASIS Certificate and Competency Board, Inc. (OCCB) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,

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Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

Cc: Debora A Terkay, RN, MS
    Office of Clinical Standards and Quality

CATEGORY 2

Can a comprehensive assessment be started before the SOC date?
Question 1: I understand the comprehensive assessment cannot be completed before the SOC date. Does that mean it's OK to start it at the initial assessment as long as it is not completed until on or after the SOC date?
Answer 1: The SOC is established on the day the first billable service is provided. The SOC comprehensive assessment must be completed on or within 5 days after the start of care date. An initial assessment may be performed prior to the SOC date, (e.g. RN admitting for a therapy only case). If agency policy is for the RN to perform the initial assessment during a non-billable visit in order to meet the Condition of Participation (484.55) time requirement of 48 hours for the completion of the initial assessment, and the RN does not provide a billable service, the SOC is not yet established. If the PT does not visit that same day, the date of the RN's initial assessment visit is not the SOC date. If the PT visits the next day, the SOC date is the day the PT visits and provides a billable service. While the RN likely conducted at least part of a comprehensive assessment in order to meet the requirements of an initial assessment visit to determine immediate care and support needs of the patient, any information collected on that date may not contribute to the SOC comprehensive assessment, as it was collected prior to the SOC date. The SOC comprehensive assessment that will include the OASIS data that will be transmitted to the state as the SOC assessment must be collected on or within 5 days after the SOC date, not before.

CATEGORY 4a

Using "old" OASIS forms in 2008
Question 2: May home health agencies continue to use up their inventory of Patient Tracking Sheets with the 2003 date, since the 1/2008 OASIS changes did not affect these items? If the date at the bottom of the form says that it is 10/2003 will these be noncompliant with any CMS requirements?
Answer 2: Since the OASIS items on the Patient Tracking Sheet (PTS) are not changing in the 01/08 OASIS data set, agencies that have an inventory of PTSs with a 2003 date may continue to use their stock until it is depleted. This exception applies only to the PTS. No other OASIS 2003 data set forms may be used after 01/2008.

Payers using "old" OASIS version
Question 3: I have been getting conflicting information regarding the process for billing Medicare Advantage PPS Payers after 1/1/2008. I have been told that we may need to continue to use the OASIS 1.5 assessment after 1/1/2008 for some of our Medicare Advantage PPS payers. We were planning on moving to 1.6 assessments for all payers. How do we proceed?
Answer 3: The Conditions of Participation require that the current version of the OASIS data must be collected on patients requiring OASIS data collection, including skilled Medicare and

Medicaid patients (including Medicare HMOs and replacement plans such as Medicare Advantage). The OASIS 1.6 will be required as of January 1, 2008 (and earlier for patients recertified in the final 5 days of the year for episodes beginning in 2008).

In order to determine a payment amount, Non-Medicare PPS payers (including Medicare HMOs) who choose to pay using a "Medicare PPS-like" model may choose to "upgrade" to the PPS 2008 model (which requires OASIS 1.6), or they may continue to use the original home health PPS model, which may require the agency to provide OASIS 1.5 data (and/or an HHRG calculated from OASIS 1.5 data under the "old" grouper specifications). Home health agencies and payers enter into business arrangements in which both agree to a specific payment methodology and requirements. Such arrangements (like basing payment on the previously required versions of OASIS), do not negate the federal regulatory requirement to collect and submit to the state survey agency the current version of the OASIS items for OASIS-eligible patients.

Formatting OASIS 1.6 in documentation
Question 4: We use a commercial vendor software product for OASIS data collection. When printing their new OASIS 1.60 assessments, the item does not appear exactly as published by CMS (e.g., doesn't include bolding, underlining) Also, the M0230/M0240/M0246 table or grid is formatted differently on the assessment screens and printouts due to a limited amount of space on the screen. Our vendor has assured us that the OASIS extract and HHRG scores are going to be accurate. Must the OASIS items (on the screen and when printed) match the data set language and format exactly? Or are these kinds of formatting modifications acceptable, as long as the OASIS extract is accurate?
Answer 4: Chapter 2 of the OASIS Implementation Manual directs "The OASIS data set must be incorporated into the HHA's own assessment, exactly as written." Chapter 7 of the Implementation Manual, pg. 7.3, states "Whether paper and pen documentation or a point of service electronic approach is utilized, several general principles for integration of OASIS items must be followed. These include: a. *Items in the revised clinical documentation must be exact (verbatim) duplicates of the OASIS items.* Emphasis added to items by underlining, boldface, and capitalization must be retained. (In point of service record-keeping systems, such emphasis can be made through use of highlighting approaches other than boldface, but it should be included.) Uniformity of data collection cannot be assured if modifications are made to the items." Additionally, on page 7.9, it states "Ascertain that changes inserted in the forms do not cause parts of one OASIS item to be printed on two different pages or columns."

The OASIS hard copy information for the chart printed out by a point of care system must match the OASIS-B 1.6 data set exactly, including formatting and wording for the items. If the printout of the assessment (i.e., the "hard copy" to be retained in the patient's clinical record) does not match the assessment data entered and submitted to the state, that may be problematic for the following reasons: 1) State surveyors will likely review records and compare the record on site in the agency with the data submitted to the state; 2) If a patient record was requested by the Fiscal Intermediary for medical review, it would be imperative that the printed record match the data collected and submitted to the state (since the same data were used to document the 485 and calculate the billing codes); and 3) One way for an agency to monitor quality is to review responses to OASIS items in clinical records and compare those responses with data collected at prior and subsequent visits to the same patient. If any of these processes would be complicated by the printouts received from your system, it could create problems for the agency.

Due to the size and complexity of M0230/240/246, the formatting may be modified to fit the computer screen as long as the hard copy print out matches the data set and the modification in no way impacts the accuracy of the item scoring.

CATEGORY 4b

<u>M0110</u>
Question 5: When completing M0110, do we include episodes of care provided in 2007?
Answer 5: When completing M0110, all adjacent Medicare Fee-for-Service episodes should be considered, including those that occurred prior to January 1, 2008.

Question 6: When we collect OASIS for a private insurance or Medicare HMO patient because the payer source pays using a "Medicare PPS-like" model, how do we answer M0110, Episode Timing? To select a response, do we define an episode as just Medicare PPS paid episodes? Or for these non-Medicare PPS patients, should we define an episode as any paid by a payer using the PPS model?
Answer 6: M0110 was developed for use in refining the PPS model and payment for the Medicare home health benefit. In that analysis, the definition of episode is specific to those episodes where Medicare fee-for-service (PPS) is the payer. When M0110 is collected on an OASIS-required patient and/or to facilitate Medicare PPS payment, this definition must be applied. If a non-Medicare PPS payer requests/requires information on episode timing to be collected using different definitions or parameters, the "payer-specific" information should be collected separately from the established OASIS items (i.e., the M0110 item should not be used, with parameters different that those required by CMS, to gather other payer-specific data).

Question 7: When the clinician is unsure if there have been any adjacent episodes, is it better to report M0110 Episode Timing as "early" or "unknown" (which defaults to "early")? If Medicare makes the adjustment automatically to correct this if it was wrong, will it make a difference if we marked "early" vs. "unknown" initially?
Answer 7: The use of the unknown response for M0110 may be impacted by agency preference/practice. Some agencies may choose not to invest the resources necessary to determine whether episodes are early or later episodes, and it is perfectly acceptable for an agency to select "UK" consistently for M0110. Other providers who want to ensure an accurate RAP payment in the case of later episodes may choose to invest the resources to determine which episode the patient is in, and this is also compliant practice. Marking "early" and "unknown" have the same effect on payment calculations. If a M0110 response is determined to be inaccurate at the time of the final claim, payment will be auto-adjusted to the correct episode amount.

Question 8: How will episode timing work on existing patients that are due for recertification in 2008. Example: Pt admitted in April 2007, due for 5th recert in Feb 2008. Will this be a later episode?
Answer 8: In the scenario you describe, the patient would have had 4 prior adjacent episodes at the point at which you are completing the 5th Recertification assessment in February 2008, so M0110 would be answered with Response " 2 – Later", as long as the episodes of care qualify as adjacent episodes. In order to qualify as adjacent, they must have been provided under the Medicare Traditional Fee-for-Service benefit (paid by PPS) and have no more than 60 days from the last day of one episode until the first day of the next episode. Since the episodes were continuous recertifications, and assuming Medicare PPS was the payer for the episodes, these would be considered adjacent episodes.

Question 9: A patient is admitted to Agency A on July 5th, 2007 (with an end of payment episode date of Sept 2nd) , then recertified on Sept 3rd (with an end of episode date November 1st, 2007). Agency B admits on Jan 1, 2008. Is agency B's episode Early or Later?

Answer 9: When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode.

Adjacent episodes are defined as those where the number of days <u>from the last day of one episode until the first day of the next</u> episode is not greater than 60. The first day after the last day of an episode is counted as day 1, and continue counting to, and including, the first day of the next episode. In the scenario presented,. In this example, November 1st was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1st would be reported by Agency B as "early".

December 31 represents day 60 in this example.   If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60.   The episode starting December 31 would be reported by Agency B as "later."   All other episodes beginning between November 2 and December 31 in this example would also be reported as "later."

Question 10: Agency 1 provides 90 days of care (1 and 1/2 episodes) under Medicare PPS and the patient is discharged. Agency 2 admits under Medicare PPS and begins care at what would have been a day in the 2nd episode (lets say day 45 in the second episode) had agency 1 still been caring for the patient. Is agency 2 still in an early episode? Or is this now a later episode for M0110?

Answer 10: It would be reported as a later episode. Agency 1 provided care for one full payment episode, then recerted to establish a second payment episode, though the patient was discharged before the end of this 2nd episode. A partial episode payment will apply to the 2nd episode when Agency 2 admits the patient to their service under Medicare PPS, and the episode started by Agency 2 will be the third adjacent episode because there was not more than 60 days between the last billable visit provided by Agency 1 and the first billable visit provided by Agency 2. Since it was the third in a series of adjacent episodes, it should be reported as "Later" for M0110.

Question 11: If a Medicare PPS patient is admitted and discharged with goals met several times within one 60 day period, is each admission counted when determining early vs later episodes? For example, a patient is admitted 10/1 and discharged 10/15 (episode #1- early?), then readmitted 10/30 and discharged 11/15 (episode #2-early?), then readmitted 11/20 (episode #3- later?). Would this represent 3 distinct episodes, for the purpose of determining M0110 Episode Timing?

Answer 11: For M0110, episodes are considered adjacent if there was no greater than 60 days between the last day of one Medicare Fee-for-Service (MC FFS) or PPS payment episode and the first day of the subsequent PPS payment episode. If a home care agency admits a Medicare patient and they had not been in a Medicare FFS Payment episode in the 60 days prior to the admission, the correct M0110 response would be "Early". If this patient was under the Medicare FFS benefit on 10/1 and was then discharged 10/15 and readmitted 10/30, a new payment

episode would begin. The agency would receive a partial episode payment for the 10/1 - 10/15 episode. When an episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last billable visit date is the end of the episode. When completing M0110 at the 10/30 episode, the patient would still be in an "Early" episode, as it would be the second in a series of adjacent episodes (assuming there was not an additional adjacent episode previous to the 10/1 episode). If that patient was then discharged on 11/15 (receiving a PEP payment) and readmitted on 11/20, the correct response to M0110 would now be "Later" as the patient would be in the third adjacent episode in the series.

M0110 (and M0826)
Question 12: How would an agency report M0110 and M0826 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don't* require a HIPPS Code?
Answer 12: If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M0826 should reflect the number of reasonable and necessary therapy visits planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M0826 should be answered NA.

The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient's payer to determine if they require a HHRG/HIPPS.

Question 13: I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this?
Answer 13: If M0110 or M0826 are marked as 'Not Applicable' then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state's OASIS Education Coordinator.

M0150
Question 14: CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare is always a likely secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactive the assessments altogether, since OASIS data collection/submission is not required for Private Pay patients only?
Answer 14: M0150, Current Payer Sources, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare eligibility criteria are met, Medicare is always a likely payer and may be included in M0150. This action will ensure that OASIS data is collected in the event, Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, transfer, ROC, discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the state, or inactivating affected assessments will not adequately remove the patient from the data base. If the assessment is not deleted, the patient identifiable data will remain in the data base, and may inappropriately impact the agency's OBQI and OBQM reports.

Question 15: CMS Q&A Category 4b Q24 states that if a patient is involved in an auto accident the M0150 response should be 1 or 2 as appropriate for that patient. Would we also pick response 11 - Other and enter auto insurance or UK - Unknown?

Answer 15: Response 8 - refers to private <u>health</u> insurance. Response 11 – Other (specify) would be selected for home care services expected to be covered by auto insurance.

M0240

Question 16: When reporting secondary codes in M0240, must codes be listed in order of their severity rating? Or according to the significance to the plan of care?

Answer 16: This mailbox is made available specifically to support the educational needs of home health providers and stakeholders related to OASIS data collection guidelines and requirements. In order to ensure that this focused need can be maintained, only the portion of the question related to OASIS data collection and guidance will be addressed.

Chapter 8 of the OASIS User's manual shares the guidance below related to primary and secondary diagnoses as well as the severity rating:

Under Response-Specific Guidance:

Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care.

Secondary diagnoses in M0240 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. The Medicare Home Health Diagnosis Coding document is found at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp.

Under Assessment Strategies:

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past. The current ICD-9-CM guidelines should be followed in coding these items.

At this time there is no OASIS guidance suggesting you must rank diagnoses by their severity rating and this mailbox focus is dedicated to OASIS guidance. You may benefit from checking with your RHHI, the Claims Processing Manual and Official ICD-9-CM Guidelines for Coding and Reporting for further guidance related to ICD-9 coding/sequencing.

M0246

Question 17: If a V code is used in M0230 and a different V code in M0240 that both replace the same case mix diagnosis should you report the case mix diagnosis twice in M0246?

Answer 17: The general OASIS data collection instruction for M0246 - Payment Diagnosis is that if a V code listed in M0230 or M0240 is reported in place of a case mix diagnosis, the agency may optionally list the appropriate case mix diagnosis in the M0246 field in the same

row as the corresponding V code. Current OASIS data collection guidelines are not any more specific related to directing providers to alter this general instruction in situations in which this general guideline may or may not be necessary, based on reimbursement impact.

Providers should be aware that the completion of M0246 (at any and all levels) is always optional, and that ICD-9 codes provided in M0246 may, under certain but not all conditions, impact payment under the Medicare PPS. Providers are encouraged to reference official ICD-9-CM coding guidelines for appropriate coding practices, and review the details of the PPS model and associated tables for details on when and how the use of ICD-9 codes reported in M0230/M0240 & M0246 impact reimbursement. You can access PPS related guidance from the CMS Home Health Agency Centerhttp://www.cms.hhs.gov/center/hha.asp

M0250
Question 18: Is medication administered via the transdermal route considered an infusion (Response 1) for M0250, Therapies at Home?
Answer 18: A transdermal medication is absorbed through the skin and should <u>not</u> be considered an infusion for M0250, Therapies the patient receives at home. M0250 Response 1 IV or infusions involve a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device, such as an eclipse bulb.

M0440 Tracheostomy & Thorocostomy
Question 19: Are tracheostomies and thoracostomies excluded from M0440?
Answer 19: There has been conflicting guidance posted on various industry list serves in the recent past. Although some recent guidance from a CMS source referenced otherwise, after further discussion, consensus has been achieved that tracheostomies and thoracostomies are ostomies and excluded from M0440.

M0440
Question 20: When an ostomy stoma has peristomal skin breakdown is that considered a lesion?
Answer 20: The stoma (ostomy) is excluded from consideration at M0440, but if there is peristomal breakdown, (cellulitis, ulceration, etc.) the area of breakdown would be considered a lesion.

M0680 and M0700
Question 21: We have several nurses that have recently joined our staff, all coming from the same agency. They were taught that on all OASIS questions if there is the word OR in bold that if both sides of the word "OR" pertained to the patient, then the patient would automatically be scored at the next level down. For example on question M0700, if the patient requires use of a device to ambulate AND needs human supervision on unlevel surfaces then the patient would be scored as a #2 which says "able to walk only with the supervision or assistance of another person at all times". However on M0680 transfer question they are marking a "0" saying the patient is on a level surface so the patient can independently get to the toilet with a device. Our software does not want to accept this; it considers it an inconsistency in data.
Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement, that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "2" on M0700 for ambulation, can the patient be a "0" independent in toileting?

Answer 21: When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 8 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M0670 Bathing says "Able to bathe self in shower or tub independently. If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M0700, Ambulation/Locomotion, response option 2 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently is reported as a "1" (See CMS OASIS Q&A Category 4b Question 155 for further guidance related to scoring M0700).

For M0690, Transferring, Response 1-Transfers with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "2" for M0700, Ambulation/Locomotion. A patient can only be scored a "0" for M0680, Toileting, if they can get to and from the toilet independently with or without a device. It would be possible for a patient to be a "2" for M0700, Ambulation/Locomotion and also be reported as a "0" for M0680, Toileting, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet safely and without assistance using a wheelchair.

M0720
Question 22: How should I respond to M0720 when my patient's diet consists entirely of enteral nutrition? Is this item asking about the patient's ability to plan and prepare a light meal or her specific diet? If the diet consists of tube feedings, should I assess her ability to open enteral nutrition cans, fill the bag with the liquid? Isn't this what should be considered for M0810?

Answer 22: When a patient's prescribed diet consists of enteral nutrition, the clinician must assess the patient's ability to plan and prepare their prescribed diet, not a light meal they wouldn't otherwise consume. The clinician will need to determine if the patient can plan their meals/feedings? Do they know which product they are prescribed and how much they should receive in a day? Can they prepare the feeding, if preparation is required? If the feeding is provided in a fully prepared state, no preparation would be required. If the feeding requires preparation, e.g. addition of water to a dry powder, determine if the patient can prepare the feeding? M0810, Patient Management of Equipment reports their ability to set up, monitor and change the feeding equipment, add the appropriate fluids to the infusion bags and clean/store/dispose of the feeding equipment or supplies, so those tasks are not reported in M0720.

M0780
Question 23: If a patient requires two or more of the types of assistance listed in response 1 of M0780, (e.g., the patient needs individual dosages to be prepared in advance, AND the patient also requires daily reminders in order to be able to take oral medications), would response 1 be appropriate? Or should response 2 be reported?

Answer 23: When scoring M0780, Management of Oral Medications, if someone else must prepare individual doses in advance for the patient AND the patient also requires someone to given them reminders in order to safely take the right med, in the right dose at the right time, the patient would be scored a "2-Unable to take medication unless administered by someone else". In order for the patient to be scored a "1", they would need to only require EITHER (a) individual dosages are prepared in advance by another person; OR (b) given daily reminders; OR (c) someone develops a drug diary or chart.

M0800
Question 24: The patient has B12 injections ordered monthly which are/will be given in the home. At the SOC/ROC visit, the schedule for the injection does not fall on the day of the SOC/ROC or Discharge visit. Since our assessment should reflect what is true on the day of assessment, Is N/A, No Injectable medications prescribed the correct response to M0800 in this circumstance?
Answer 24: The M0800 response "NA-No injectable medication prescribed" would not be appropriate in the situation described because the patient has an order to receive injectable medication during the episode. Even though the medication will not be injected on the day of the assessment, the clinician would assess and report the patient's ability by following the guidance in the Chapter 8 assessment strategies. It states "If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration."

M0800
Question 25: In a previous CMS Q&A, Question 168, the answer directs that there should be no automatic assumption the patient cannot administer an injectable medication even if the physician orders the nurse to administer it. If I understand that, it means that the patient's physical and cognitive ability to administer injectable medications is assessed and used to report M0800 anytime the patient is receiving an injectable medication in the home, even if the physician is ordering administration by the nurse?
 Answer 25: The previous CMS Q&A you referenced has been recalled. If a physician orders the nurse to administer a prescribed injectable medication, the patient's ability is reported as "2-Unable to take injectable medications unless administered by someone else." The order for the nurse to administer the medication represents a medical restriction against patient self-administration. When a patient is medically restricted from performing an activity, the impact of this medical restriction on the patient's ability must be considered.

M0826
Question 26: We are having a huge discussion as to what the meaning of the new M0826 question implies. At present if the admission is done by nursing any rehabilitation service is put on the 485 (plan of care) as a 1 day 1 for evaluation and treatment. Then later the rehabilitation service enters their own orders and frequency as a verbal order after they have completed therapy evaluation. The way the new M0826 reads, some feel the nurse must put on the 485 a total of rehabilitation visits to match the OASIS number placed in the blank even though the rehabilitation service may or may not have made their evaluation visit to the patient by the time the POT and OASIS are to be completed. We realize CMS will adjust the actual number of visits later as the claim is processed but are we expected to put the guess on the 485 at the start of care? Is this a compliance issue?
Answer 26: Chapter 8 of the OASIS User's manual, on page 8.112, states under the Definition "Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the

treatment of the patient's illness or injury." It further states under Assessment Strategies "If the number of visits that will be needed is uncertain, provide your best estimate."

<u>M0826</u>
Question 27: I am entering an assessment into HAVEN using the B1-0108 form. I do not require a HIPPS code how should I complete M0826 to not receive a HIPPS Code?
Answer 27: If a HIPPS Code is not required you may leave 'Number of Therapy Visits' blank and check 'Not Applicable'. Note: If 'Not Applicable' is checked then 'Number of Therapy Visits' must be blank.

<u>M0826</u>
Question 28: Following the instructions for Therapy Need for the OASIS B-1 (1/2008), when adding the number of therapy visits, must a "0" be placed before the number or will values less than 100 be recognized without "0" preceding them? For example, if you project 11 visits, should you put 011 or just 11?
Answer 28: If M0826 Therapy Need is not marked N/A, then the 1.60 OASIS Data Specs require that M0826 must report a number that is "zero filled and right justified". The number of therapy visits entered into M0826 must range from 000 to 999. If there are less than 3 digits in the number the therapy visits to report, the number must be preceded by zeros. For example, "11" visits should be entered as "011".